(3) Services included in an optional supplemental plan under (§ 417.440(b)(2)) are subject only to a grievance procedure.

(4) Physicians and other individuals who furnish services under arrangement with an HMO or CMP have no right of appeal under this subpart.

(c) *Applicability of other regulations.* Unless otherwise provided in this subpart, regulations at 20 CFR, part 404, subparts J and R, (pertaining respectively to conduct of hearings and representation of parties under title II of the Act) are applicable under this subpart.

[60 FR 46233, Sept. 6, 1995]

§ 417.605 Immediate PRO review of a determination of noncoverage of inpatient hospital care.

(a) *Right to review.* A Medicare enrollee who disagrees with a determination made by an HMO, CMP, or a hospital that inpatient care is no longer necessary may remain in the hospital and may (directly or through his or her authorized representative) request immediate PRO review of the determination.

(b) *Procedures.* For the immediate PRO review process, the following rules apply:

(1) The enrollee or authorized representative must submit the request for immediate review—

(i) To the PRO that has an agreement with the hospital under § 466.78 of this chapter;

(ii) In writing or by telephone; and

(iii) By noon of the first working day after receipt of the written notice of the determination that the hospital stay is no longer necessary.

(2) On the date it receives the enrollee's request, the PRO must notify the HMO or CMP that a request for immediate review has been filed.

(3) The HMO or CMP must supply any information that the PRO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review.

(4) In response to a request from the HMO or CMP, the hospital must submit medical records and other pertinent information to the PRO by close of business of the first full working day immediately following the day the HMO or CMP makes its request.

(5) The PRO must solicit the views of the enrollee who requested the immediate PRO review (or the enrollee's representative).

(6) The PRO must make a determination and notify the enrollee, the hospital, and the HMO or CMP by close of business of the first working day after it receives the information from the hospital, or the HMO or CMP, or both.

(c) *Financial responsibility.* (1) *General rule.* Except as provided in paragraph (c)(2) of this section, the HMO or CMP continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the PRO notifies the enrollee of its review determination.

(2) *Exception.* The hospital may not charge the HMO or CMP (or the enrollee) if—

(i) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate PRO review; and

(ii) The PRO upholds the noncoverage determination made by the HMO or CMP.

[59 FR 59941, Nov. 21, 1994]

§ 417.606 Organization determinations.

(a) *Actions that are organization determinations.* An organization determination is any determination made by an HMO or CMP with respect to any of the following:

(1) Payment for emergency or urgently needed services.

(2) Any other health services furnished by a provider or supplier other than the HMO or CMP that the enrollee believes—

(i) Are covered under Medicare; and

(ii) Should have been furnished, arranged for, or reimbursed by the HMO or CMP.

(3) The HMO's or CMP's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO or CMP and the enrollee has not received the services outside the HMO or CMP.

(b) *Actions that are not organization determinations.* The following are not organization determinations for purposes of this subpart:

(1) A determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding services included in an optional supplemental plan (see §417.440(b)(2)).

(c) *Relation to grievances.* A determination that is not an organization determination is subject only to a grievance procedure under §417.436(a)(2).

[59 FR 59942, Nov. 21, 1994]

§417.608 Notice of adverse organization determination.

(a) If an HMO or CMP makes an organization determination that is partially or fully adverse to the enrollee, it must notify the enrollee of the determination within 60 days of receiving the enrollee's request for payment for services.

(b) The notice must—

(1) State the specific reasons for the determination; and

(2) Inform the enrollee of his or her right to reconsideration.

(c) The failure to provide the enrollee with timely notification of an adverse organization determination constitutes an adverse organization determination and may be appealed.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59942, Nov. 21, 1994]

§417.610 Parties to the organization determination.

The parties to the organization determination are—

(a) The enrollee;

(b) An assignee of the enrollee (that is, a physician or other supplier who has provided a service to the enrollee and formally agrees to waive any right to payment from the enrolee for that service);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other entity determined to have an appealable interest in the proceeding.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59942, Nov. 21, 1994]

§417.612 Effect of organization determination.

The organization determination is final and binding on all parties unless it is reconsidered in accordance with §§417.614 through 417.626, or revised in accordance with §417.638.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59941, Nov. 21, 1994]

§417.614 Right to reconsideration.

Any party who is dissatisfied with an organization determination or with one that has been reopened and revised may request reconsideration of the determination in accordance with the procedures of §417.616.

[59 FR 59942, Nov. 21, 1994]

§417.616 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with—(1) The HMO or CMP that made the organization determination;

(2) An SSA office; or

(3) In the case of a qualified railroad retirement beneficiary, an RRB office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, the request for reconsideration must be filed within 60 days from the date of the notice of the organization determination.

(c) *Extension of time to file a request.* (1) *Rule.* If good cause is shown, the HMO or CMP that made the organization determination may extend the time for filing the request for reconsideration.

(2) *Method of requesting an extension.* If the time limit in paragraph (b) of this section has expired, a party to the organization determination may file a request for reconsideration with the HMO or CMP, HCFA, SSA, or, in the case of qualified railroad retirement beneficiary, and RRB office. The request to extend the time limit must—

(i) Be in writing; and

(ii) State why the request for reconsideration was not filed timely.

(d) *Parties to the reconsideration.* The parties to the reconsideration are the parties to the initial determination as described in §417.610, and any other person or entity whose rights with respect to the initial determination may